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"Medicaid Prescription Drugs: Examining Options for Payment Reform"

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Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today on behalf of the Arizona Health Care Cost Containment System (AHCCCS). I am appreciative for the opportunity to share how Arizona's Medicaid program has been successful in keeping the cost of prescription drugs significantly lower than other states' Medicaid programs.

<u>The AHCCCS Model</u>

Arizona's Medicaid program operates under a Section 1115 Research and Demonstration Waiver granted by CMS in 1982. This waiver allows Arizona to operate a statewide managed care system and requires that all Medicaid members enroll in a contracted health plan. AHCCCS pays the health plans an actuarially determined per-member, per-month (PMPM) capitation for each enrolled member. Under this model of contracting, the health plans assume the financial risk of delivering the full range of health care services for each member. The current Acute Care Medicaid program and State Children's Health Insurance Program (SCHIP) includes over 1 million low-income members.

In Arizona, the capitation paid to the health plans is for the provision of all Medicaid services, including the prescription drug benefit. The inclusion of the prescription drug benefit in the managed care capitation rate disqualifies AHCCCS from participation in the Medicaid Rebate Program. Nonetheless, this factor has not had a negative impact on AHCCCS. This exclusion makes our health plans 100% at risk for the cost of prescription drugs, creating a strong motivator for them to deliver a cost effective prescription drug benefit focusing on the use of generics.

Benefits to health plans for being at-risk for delivering prescription drug services

Because AHCCCS' health plans assume full financial risk for delivering the entire range of Medicaid health care services, including prescription drugs, AHCCCS allows each health plan, or Managed Care Organization (MCO), to develop its own plan-specific formulary and prescription drug benefit management tools. In addition to this inherent financial incentive, the health plans also have a constant incentive to maintain quality services because they must compete for membership enrollment. Thus, the health plans work to meet the needs of the members and to provide a cost-effective benefit. With this in mind, there is no single, statewide Medicaid formulary. The health plans develop formularies based on input of their provider network, often locally or regionally, that are reinforced with contractual relationships with providers for compliance.

AHCCCS health plans utilize a variety of tools to maintain cost efficiency. The most significant factor may be that AHCCCS health plans mandate generic drug utilization. The overall AHCCCS dispensing rate average for generics is 70+%. When generic drugs are available, our health plans average 98 + % generic dispensing rate. Our experience has been that using generic drugs is more cost effective for Arizona than using brand drugs and receiving a rebate.

In addition, health plans have the ability to develop closed pharmacy provider networks, which routinely provide aggressive Average Wholesale Price (AWP) discounts and are negotiated in highly competitive environments (15-17% for brand and 15-50% or greater for generics). Maximum Allowable Cost (MAC) pricing for generics is also used. The dispensing fees are very low compared to other states, averaging less than $2 per RX.

In addition to the mandated generic utilization and the closed pharmacy provider networks, health plans utilize other management tools to keep their prescription drug costs low. These tools in and of themselves are not exceptional and are widely used:

- Step Therapy/Treatment Guidelines which look for evidence of failure to achieve desired treatment outcomes with less costly, generic or over the counter drugs and develop compliance with standards of care or medical specialty developed treatment guidelines;
- Prior Authorization Procedures;
- Quantity Limits such as early refill edits and maximum monthly quantities; and
- Disease Management Program/Specialty Case Management for members with Diabetes, Asthma, Heart Disease and others.

When used in conjunction with the emphasis on generic drug use, and motivated health plans, these tools become a significant factor in quality care and cost savings.

<u>Benefits to AHCCCS Members When Pharmacy Services are Well Managed</u>

AHCCCS is the largest single health insurer in the state with membership at almost 20% of Arizona's population. Strong utilization management by our health plans and monitoring of quality benchmarks have kept costs under control so that the members enjoy no limits on the number of prescriptions or, when necessary, brand name prescriptions which they can receive per month. AHCCCS carefully monitors our managed care plans to ensure that members receive the services they need. Very few quality of care issues are related to drug therapy. Out of an estimated 1,200 Quality of Care issues annually, less than 1% is related to prescription drugs.

<u>Arizona Model Produces Cost Savings</u>

A recent study done by the Centers for Health Care Studies (CHCS) and the Lewin Group compared prescription drug costs of the aged, blind and disabled population enrolled in AHCCCS' Acute Care Program to similar populations of other states. By definition, these populations are heavy utilizers of prescription drugs. The CHCS/Lewin evaluation found that AHCCCS' prescription drug costs provided through the managed care model are more cost effective than other states' fee-for-service models. AHCCCS' 2002 per member per month (PMPM) prescription drug utilization cost was $112.21, which is 38% below the National Average of $181.01 and is 11% below the next most cost-competitive state (Michigan). This is even more impressive when one considers that these savings were achieved without the benefit of rebates.

The following table illustrates the various elements of both AHCCCS' prescription drug benefit in a managed care model and other states' prescription drug benefit in a fee-for-service model. The data was self-reported by the State Medicaid pharmacy program administrators from each state in response to a national survey.

State	Generic Utilization	Reimbursement Formula	Dispensing Fee	Copay-ment	Max days Supply	Monthly Limit	Prior Auth Program
Az	70%	AWP-15-17% (negotiated by each heath plan)	$2	$0	Greater of 30 days or 100 units	None	Yes
Ak	42%	AWP-5%	$3-$11	$2	30 days	None	Yes
Ca	51%	AWP-17%	$7.25-$8	$0	100 days	6	Yes
Mi	Not reported	AWP-13.5% (independent pharmacies) and AWP-15% for chain pharmacies	$3.77	$1	Maintenance meds – 3 months; all others 34 days	None	Yes
NJ	48%	AWP-12%	$3.69	$0	Greater of 34 days or 100 units	None	Yes
Pa	51%	AWP-10%	$4	$1	Greater of 34 days or 100 units	None	Yes

Challenges to Lowering Prescription Drug Costs for Non-Managed Care Populations

While the Arizona model of Medicaid managed care has been a success story for our state, it must be acknowledged that it may be difficult to convert from a fee-for-service program to a Medicaid managed care model. While commitment to the model has paid off relating to both cost-efficiency and quality of care, the first 5 years of operating the AHCCCS program were difficult.

Conclusion

There are several points I would like to leave you with today to assist you as you identify strategies to reduce Medicaid prescription drug costs. The first is a paradox. By improving compliance and utilization of prescription drug regimens, drug spending may actually rise. However, this may lead to improvements in health status and decreased overall health care spending. While this is the ultimate goal we are all striving to meet, it sometimes makes it more difficult to evaluate the "success" of cost-containment initiatives.

Secondly, the ability to have common data elements and the ability to analyze data that cuts across health plans, and across state Medicaid programs, is critical to ensuring that prescription drugs are having the maximum effect of improving health status. Quality performance indicators and benchmarks can be set for managed care organizations and health plans without compromising their ability to deliver health care services. Another challenge that will affect states' ability to manage prescription drug costs is the implementation of Medicare Part D under the Medicare Modernization Act of 2003 (MMA) on January 1, 2006. Due to the fact that the states will no longer be providing coverage to the dual eligible population (members eligible for both Medicaid and Medicare), states are losing critical purchasing power. Arizona is concerned that the phased-down payments will not be indicative of the savings that have been achieved in providing a prescription drug benefit. This will be especially true if the trend to provide brand name drugs over generics is realized. At the same time, the MMA creates the opportunity for states to enhance the coordination of care for the dual eligible population through collaboration with Part D Plan Sponsors. By providing incentives for plans to become Medicare Advantage – Prescription Drug Plans designated as Special Needs Plans, members will be able to access both their Medicaid and Medicare services through one health plan, allowing for greater coordination of care and coordination of benefits. AHCCCS has collaborated with six of its contracted health plans pursuing such designation. The provision of all of the member's services by one health plan supports the notion of person vs. program and allows the maximum opportunity for members to receive quality, coordinated care without navigating two delivery systems.

Another challenge Medicaid faces is the cost of providing long-term care services. Arizona provides long-term care services through a managed care model, the Arizona Long-Term Care System (ALTCS). ALTCS controls the cost of providing long-term care services by utilizing a Pre-Admission Screening document allowing only those members at risk of institutionalization to enroll in ALTCS rather then Acute Care Medicaid. The managed care model allows for imposition of network standards and case management standards that enhance the quality of services members receive. Members may choose to receive Home and Community Based Services (HCBS) rather than enter an institution, which is a savings for Medicaid as well as an effective way to allow members to direct their own care.

I am available to take any questions you may have and want to thank you again for the opportunity to highlight how our program is working for the benefit of Arizonans.